SUBCOMMITTEE ON
MENTALLY ILL RESIDENTS IN ADULT CARE HOMES

Wednesday, October 11, 2006
1:30 PM
Room 544, LOB

The Subcommittee on Mentally Ill Residents in Adult Care Homes met on Wednesday, October 11, 2006, at 1:30 PM in Room 544 of the Legislative Office Building. Members present were: Representative Beverly Earle, Co-Chair; Representative Verla Insko, Co-Chair; Senators Stan Bingham and Charlie Dannelly and Representatives Debbie Clary, Bob England, and Carolyn Justice.

Shawn Parker, Ben Popkin, Andrea Russo, Carol Shaw, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She said that the committee meeting was a joint subcommittee of the Study Commission on Aging and the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. She said the goal of the subcommittee was to seek an outcome to the housing situation regarding the adult mentally ill and to recommend legislation to the 2007 General Assembly.

Dr. Bonnie Morrell from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, addressed adult care services and where the adult mentally ill reside. (See Attachment No. 2) She announced that the public mental health system served over 174,000 adults with mental illness last year. Of that number, 1,149 lived in licensed mental health homes; 5,000 lived in adult care homes (ACH); and many lived independently in the community and received services. In order to live independently, these individuals must either receive a rent subsidy or have enough money to pay rent, and they must be able to receive necessary services as appropriate. Nationally, approximately 10% of adults with serious mental illness need specialized housing. Dr. Morrell briefly described how a person in need of help would access services, stating that there was a 24-hour-a-day phone number to call. Their need is screened and assessed as to whether it is an emergency or routine need and they are then connected to the appropriate provider. The number for each LME is posted under "service locator" on the Division website. She said that the new services that began in March were designed so that services would go to the consumer rather than the consumer going to an office to meet with a therapist. She also reviewed existing services for adults. Dr. Morrell said she would provide data regarding where consumers who use crisis services and are admitted to a State facility were living before entering the facility.

Dr. Morrell explained that every person receiving mental health services has a Person Centered Plan. A person that begins to experience difficulties can call the community support provider and staff from the agency would go see that person and offer assistance.

She was asked about service gaps and explained that the scenario just described would be in place once there is an adequate supply of providers in every catchment area across the State. Andrea Russo, Fiscal Research staff, was asked to provide the percentage of federal, State and county dollars going to mental health services, how it affects the LME, and where the money goes.

Dr. Morrell said that there was one mental health licensure category for residential housing for adults with mental illness. In that category, there are supervised living apartments with 488 people, 59 live with families that are paid on a temporary basis, and 594 live in group homes. The total is 1,140 living in licensed mental health settings based on reimbursement data. Housing is paid for with State funds, Medicaid does not pay for this service. She said that there was a gap in the residential treatment setting for adults with mental illness. It is an issue that is currently under study. She said that based on 2005 data, there were 24,831 residents in adult care homes and 5,000 of those had a mental illness of which 1,479 were under 50 years of age. The issue is not necessarily age but rather having a mental illness that is associated with behaviors that do not fit appropriately with the setting the person is in and the people with whom they are interacting. Representative Insko suggested that this was the population that raises the most concern and perhaps there should be a specialized setting for that population. Dr. Morrell also said that reviewing data regarding State hospitals discharging patients to adult care homes showed that in FY 2002, 5.5% of the discharges were to ACH, and in FY 2006 the number had decreased to 3.7% discharges. She said that the numbers indicate that an effort is being made for appropriate placement. For those in need of more serious treatment, a specialized residential facility that incorporates treatment is needed. ACH regulations state that they must provide personal care and support but say nothing about treatment. Patients listed with Alzheimer's and dementias are not listed as having a mental illness.

Barbara Ryan from the Division of Facility Services addressed licensing requirements. She said the definition of an Adult Care Home is a setting that provides room and board, individual personal care and assistance and or supervision. Mental health treatment would be considered an inappropriate placement. For those needing mental health services residing in (ACH), the facility would make arrangements with the LME for residents to receive appropriate treatment. If a person was coming from a State facility to an adult care home, the hospital would notify the LME. Services would most likely be provided by Medicaid. The facility pre-screens each individual to ensure that they can meet the individual's needs. If it is found that the individual needs additional care or has escalating behavior, staff would call the physician, the psychiatrist, a mental health professional, or refer the appropriate person to a magistrate to pursue involuntary commitment of the individual. If a person appears dangerous, then law enforcement would be called. Members of the subcommittee expressed concern that there may now be a need for facilities that are adequately staffed, trained, and paid to handle violent mentally ill patients. Ms. Ryan said that out of the 582 adult care homes that renewed their licenses in September of 2005, 115 had a population of 50% or greater mentally ill residents. Out of the 546 family care homes which have 2-6 beds, 222 had 50% or greater with a diagnosis

of mental illness. She was asked how many of these residents would be considered violent and agreed to locate the information.

Jeff Horton, Chief Operating Officer of the Division of Facility Services, spoke on facilities for the mentally ill. Mr. Horton said that there was no level of care between the hospital inpatient setting, the adult care home setting, and independent living setting. DFS licenses 287 mental health facilities which are categorized as supervised living for adults with mental illness. These facilities are licensed to have 2-6 beds. There are 1,319 facilities for supervised living for adults with developmental disabilities, 300 are special mental retardation homes for adults with DD. Funding was a concern for people moving from an adult care home in the community into a clubhouse setting and then into an independent living setting. Members questioned the ability to track supervised housing. Mr. Horton responded that DFS did not regulate supervised housing since it was typically an independent living arrangement. Andrea Russo responded that there was a way to track the number of units the Housing Finance Agency has financed; and also said that the Division of Community Assistance (under the Department of Commerce) has financed a small number that they report every year. It was requested that an overview with the definitions of the different levels of care be provided. Mr. Horton was asked if there were any successful models across the State where the mentally ill and other adults lived together. Lou Wilson responded that in spite of the fact that there are no rules or guidelines by the State for these facilities, there are a few that have services for residents with mental illness. She offered to gather detailed information for members.

Julia Bick from the Office of the Secretary gave an overview of the (DHHS) report on the *Study of Mentally Ill Residents in Long Term Care Facilities.* (See Attachment No. 3) She emphasized that the diagnosis of mental illness does not mean that a person is dangerous. It is also not an age issue since people of all ages can have behavioral issues. She said that the Department had already implemented pieces of the report. Beginning January 1, 2007, funding will be made available to expand the mental health specialty teams to hire an additional position to focus on the needs of younger adults in long term care setting. The Department is currently developing an RFP to identify/locate the population and the needs of the population within the adult care home system and the mental health system. While this study is going on, Ms. Bick said that the Department was moving forward to develop aspects of the plan focusing on the need for a higher level of supervision and support along with a separate program to provide adequate staffing and treatment to address the needs of this population. A draft service definition (which may be covered as a Medicaid service) has been proposed to address the high end of this continuum. She said this would be a small community-based facility (Residential Treatment Model) if approved by CMS, or funded as a State service if supported by the legislature. The facility, with 12 beds or less, would treat those not meeting the criteria for admittance to a State hospital but having problematic behavior not being adequately treated in the ACH.

Julia Budzinski from the Division of Medical Assistance reported on uniform screening. (See Attachment No. 4) She addressed 3 initiatives that directly affect ACH: 1) A uniform screening program for all Medicaid long term care services; 2) An ACH personal

care services restructuring program; and 3) A future integrated assessment system. Addressing the adult care homes admissions process, she said that the new system would put the PASAR components in effect at the initial assessment. She said that there were many problems with the FL2 process but that the three programs would eliminate that process. There will be one form to replace the multiple forms involved with the eight separate processes. The new form will be a web-based program which should reduce inappropriate placements, reduce paperwork, and provide a better picture of the population's needs. Ms. Budzinski said that the goal was to provide people with the correct service, to increase choice, and to provide appropriate placement.

Ms. Budzinski said that the Adult Care Home/Personal Care Service restructuring is a result of a 2 year process working with CMS (which did not approve of the method of reimbursement of Adult Care Homes for Personal Care Services). As a result, a kick-off meeting with stakeholders was held to look at policy, rate-setting, rules, legislation, and funding for ACH. The desired outcome is to have additional funding for additional services that will meet the needs of residents. She also noted that one Personal Care Service program will apply uniformly to the eight settings which should help streamline the system. She also said the RFP for the Integrated Assessment System should be ready soon. The system will be web-based and the pilot program should be implemented by the first of the year.

There being no further business, the meeting adjourned at 3:50 PM.

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Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant